

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 013164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/20/2014
NAME OF PROVIDER OR SUPPLIER SOLANA SENIOR LIVING, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 7721 BATTERY POINTE WAY INDIANAPOLIS, IN 46240		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00159442.</p> <p>Complaint IN00159442 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey Date: November 20, 2014</p> <p>Facility number: 013164 Provider number: NA AIM number: NA</p> <p>Survey Team: Mary Jane G. Fischer RN TC</p> <p>Census bed type: Residential: 35 Total: 35</p> <p>Census payor type: Other: 35 Total: 35</p> <p>Sample: 5</p> <p>Solana Senior Living LLC was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00159442.</p> <p>Quality Review 11/21/14 by Lisa McColly</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE